STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 01 B. WING	12/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 W COLUMBIA ST EVANSVILLE, IN 47710

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/04/12 Facility Number: 000129 Provider Number: 155224 AIM Number: 100266780 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Columbia Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement was determined to be of Type II (111) construction and was	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on or after December 13, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms in the 1400 hall (1403 to 1406, and 1408), and 2400 hall (2403 to 2410) with battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 186 and had a census of 153 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one detached wood shed used for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/07/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 2 kitchenettes was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is	K0017	K017 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·No residents were affected and alleged deficiency has been corrected. ·Smoke detector has been installed in the kitchenette area that is hard wired and connected to building fire protection system**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Smoke detector has been installed in the kitchenette area that is hard wired and connected	12/13/2012

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	protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect four residents, as well as staff and visitors in the 1400 hall, plus any other residents using the 1400 hall dining room/lounge which could seat more than twenty residents. Findings include: Based on an observation with the Maintenance Director on 12/04/12 at 1:20 p.m., the 1400 hall kitchenette wall had a three foot by five foot opening into dining room/lounge which was open to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the 1400 hall kitchenette was not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		to building fire protection system. ·Maintenance supervisor, ED/designee will ensure all construction changes include hard wired smoke detection devices when required.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Smoke detector has been installed in the kitchenette area that is hard wired and connected to building fire protection system. ·Maintenance supervisor, ED/designee will ensure all construction changes include hard wired smoke detection devices when required **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Safety meeting held monthly will include review of fire safety requirements and review of any new construction or remodeling planned. **Compliance date: December 13, 2012**	

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K0029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 4 of 5 sets of double doors, hazardous area doors, to the basement corridor were equipped with positive latches and latched into their door frames. This deficient practice could affect mostly staff and visitors while in the basement area which included the kitchen, laundry room, and maintenance room. Findings include: Based on observations on 12/04/12 between 12:15 p.m. and 12:35 p.m. during a tour of the facility with the Maintenance Director, the sets of double doors from the corridor into the kitchen	K0029	K029**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·No residents were affected and alleged deficiency has been corrected. ·All doors required to have positive latches and latch into their door frames have been installed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·All doors required to have positive latches and latch into their door frames have been installed. ·Maintenance supervisor, ED/designee will ensure all construction changes include or	12/13/2012

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	(2 sets), Maintenance Room, and Boiler Room, would latch into each other, however, all four sets of double doors would not latch into their respective door frames. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b)		future installation of doors have required positive latches that also latch to their frame when required. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Audit of all double doors in facility has been conducted by the maintenance director and all are equipped with positive latch doors that latch to the frame as required. Any changes in doors will be reviewed, department heads will report any concerns about properly functioning doors to maintenance supervisor/ ED/designee immediately.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Safety meeting held monthly will include review of fire safety requirements and review of any new construction or remodeling planned.**Compliance date: December 13, 2012**	

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K0045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 6 exit means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect 30 residents, as well as staff and visitors from the 1100 and 2100 halls while using the 1100 hall exit to evacuate the facility. Findings include: Based on observation on 12/04/12 at 1:50 p.m. during a tour of the facility with the Maintenance Director, the exit means of egress outside the 1100 hall exit was equipped with one light fixture with only one bulb under the three foot soffit. Once outside the exit there was a ramp and sidewalk over 75 feet to the public way. This was acknowledged by the Maintenance	K0045	K045 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·No residents were affected and alleged deficiency has been corrected. ·A second light has been installed at the 1100 hall exit **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·30 residents, as well as staff and visitors using the 110 and 2100 halls have the potential to be affected by the alleged deficient practice ·A second light has been installed at the 1100 hall exit. ·Maintenance supervisor, ED/designee will ensure all exits are equipped with lighting as required. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Audit has been conducted and all public exits are equipped with	12/13/2012

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	Director at the time of observation, furthermore, the Maintenance Director said he did not think the single light was connected to the generator. 3.1-19(b)		lighting requirements including at least 2 lights per exit. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Safety meeting held monthly will include review of fire safety requirements and review of any new construction or remodeling planned. Maintenance supervisor/ED/designee will round outside at least 5X per week x 4weeks then weekly thereafter for at least 6 months to ensure all lighting is functioning and in working order. **Compliance date: December 13, 2012**	

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K0056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 2 of 17 smoke compartments. This deficient practice could affect mostly staff and visitors while in the basement which included the kitchen, laundry rooms, and maintenance room. Findings include: Based on observations on 12/04/12 at 11:50 a.m. and again at 12:45 p.m. during a tour of the facility with the Maintenance Director, the elevator room near the employee break room and the	K0056	K056 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·No residents were affected and alleged deficiency has been corrected. ·Sprinklers have been installed in both elevator rooms in the basement **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents, as well as staff and visitors have the potential to be affected by the alleged deficient practice ·Sprinklers have been installed in both elevator rooms in the basement. **What measures will be put into place or what systemic**	12/13/2012

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	elevator room near the housekeeping storage room were not provided with automatic sprinkler coverage. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b)		**changes you will make to ensure that the deficient practice does not recur?** Maintenance supervisor audited all areas of the building to ensure sprinkler heads were in place in all required areas.Sprinklers are in place in all required areas **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Safety meeting held monthly will include review of fire safety requirements and review of any new construction or remodeling planned **Compliance date: December 13, 2012**	